Nobody's responsibility: the precarious position of disabled employees in the UK workplace

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Abstract

Secondary analysis of a qualitative data set of perceived workplace ill-treatment suggests that human resource and occupational health professionals play too subordinate, belated and haphazard a role, compared to ill-equipped line managers, in the de-escalation and resolution of ill-treatment experienced by disabled and ill employees.

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Introduction

Shortly after the UK Disability Discrimination Act 1995 (DDA), Bruyere and James (1997) examined how new disability law might influence organisational practices in the UK, suggesting that new provisions were 'likely to require employers to adopt a more proactive and integrated approach to what in the US has become known as disability management' (Bruyere and James, 1997: 5). This article refers to subsequent data on ill-treatment of employees experiencing disability and ill-health in the workplace, to examine why UK organisations appear to have failed to adopt the proactive, multi-disciplinary team approach to workplace disability envisaged by Bruyere and James (1997: 12-13) that would 'logically' be co-ordinated by human resource (HR) departments. In doing so, it explores the experiences of disabled employees, the consequences for them when organisations neglect responsibility in this area, and social policy makers' attempts to fill the gap left by employers.

In 2011, around 30% of the UK working age population reported a long-standing illness or impairment (Jones and Wass, 2013: 983). Disabled people remain significantly less likely to be employed than non-disabled people, although the gap has narrowed since the early 2000s. Increases in flexible and non-manual work and, most significantly, an overall growth in public sector employment between 1999 and 2009 are the main reasons (Dolton and Makepeace, 2010; Jones and Wass, 2013: 983-4). The widespread presence of formal disability policies, which are subject to statutory scrutiny, in the UK public sector (Hoque and Noon, 2004; Adams and Oldfield, 2012) may also indicate better employment prospects for disabled people. However, the reversal of public sector employment growth was compounded by the austerity policies of the Coalition Government from 2010, rendering

disabled people in employment particularly vulnerable (Leonard Cheshire Disability, 2011). Recessionary influences in the UK public sector have resulted in incremental work intensification, reduced job control, stricter absence procedures and 'lean' management practices (Taylor, Cunningham, Newsome and Scholarios, 2010; Carter et al., 2013; Baumberg, 2014).

A dominant focus on the employment levels of disabled people (Schur, Kruse, Blaisi and Blanck, 2009) has recently been supplemented by important data highlighting disabled employees' experiences of perceived ill-treatment in the workplace. The UK Workplace Bullying and Harassment in Britain (hereafter WBHB) project consisted of two phases; a quantitative survey and qualitative interviews. In 2007-8 the initial phase, the British Workplace Behaviour Survey (BWBS), asked current or recent UK employees (n = 3979) about their experiences of different types of perceived ill-treatment in the workplace. Reported particularly in Fevre, Robinson, Jones and Lewis (2008) and Fevre, Lewis, Robinson and Jones (2011a, 2012: 30-102), BWBS reached four key conclusions of particular relevance to disabled employees. First, disabled employees and those with long-term illnesses were more likely to report negative experiences at work than other groups with 'protected characteristics' (Fevre et al., 2008; Fevre, Robinson, Lewis and Jones, 2013).[1] Second, the type of disability and negative behaviour they experienced was important, with those identifying as having a psychological disability or illness most likely to report experiencing negative behaviour. Third, reasons for negative behaviour are varied and complex. Finally, and perhaps most significantly: 'the relationship between disability and negative behaviour is strong and pronounced, even holding constant other relevant demographic, attitudinal and workplace characteristics' (Fevre et al, 2008: 8).

[1] This finding was unexpected, given that the project's original focus was on ethnic minority employees.

Qualitative data from the second phase of the WBHB project deployed interviews with 88 employees, 22 of whom self-reported long-term ill-health or a disability,[2] to explore and contextualise employees' perceived ill-treatment in greater depth. Interviews were conducted in five large organisations across public, private and charitable sectors willing to grant access to the original researchers: a hospital trust, a financial services firm, a logistics organisation, a charity and an engineering company. Details of how the main organisational cases were selected, and participants recruited within each case, can be found in Fevre et al. (2012: 103-106). The qualitative results for the ill or disabled sub-set remain relatively unexplored, but can provide important insights into the organisational mechanics of ill-treatment in the workplace, its nature, causes and effects, and how employers interact with disabled employees. The data set is available for secondary analysis and provides a valuable opportunity to drill to interrogate further the 'how' and 'why' questions on disabled employees engendered by the quantitative BWBS data.

Debate will proceed by first examining the UK literature on disability and employment, with an emphasis on organisational level policies, practices and behaviour. Qualitative data will then be presented from interviews with ill and disabled employees in the second phase of the WBHB project around three themes derived from our analysis. These are: employers' perceived understanding of ill-health and disability, as reflected in their policies and practices; difficulties negotiating adjustments in order to perform the job; the nature and effectiveness of workplace interventions by bodies such as human resources and occupational health departments, and also employee representatives. We return in our analysis and discussion to the issues raised in our opening paragraph, and examine reasons for what appears to be a continued widespread absence of a proactive, integrated, multi-disciplinary team approach to disability in UK organisations.

[2] Interviewees were asked whether they suffered from a disability or long-term illness. It is likely that some reporting only the latter had medical conditions that were, in fact, covered by the DDA, but may not have been aware of this. We use both terms throughout this paper.

Factors influencing the management of ill and disabled employees in the UK

A relatively small body of literature in the UK has focused on the management of ill and disabled employees and, outside of disability studies, an even smaller literature has documented employee experiences of that management. Issues of job retention, absence and performance management, return to work, and legal compliance, have dominated management debates. So too has an individual interpretation of disability, which has emphasised correcting the person or body rather than the work context (Roulstone, 1998; Williams and Mavin, 2012). From the employee perspective, debates have focused on workplace adjustments ('accommodations' in US and continental European parlance); absence and disciplinary procedures; work intensification; (in)flexible working arrangements; employer and union attitudes to disabled workers; workplace bullying/ ill-treatment; stress and ill-health (Foster, 2007; Foster and Fosh, 2010; Taylor et al., 2010; Fevre et al., 2013; Danford et al., 2013). When examining these literatures it becomes apparent that the interests of different workplace actors – managers, employees, HR departments, occupational health advisors (OHAs) and employee representatives – are rarely portrayed as complementary. Examples of coordinated solutions that benefit both organisations and employees are much harder to find than in the US literature (Flynn, 2001), despite contemporary pressures on welfare expenditure providing political impetus. Baumberg (2014: 290) notes that between 1980 and 1999 the rise in incapacity claims in the UK was greater than any other OECD country, bar South Korea. The UK Government's response has been to commission a number of high profile investigations into how disabled and ill-workers can be retained in employment. The latest review (Black and Frost, 2011) suggests, like its predecessors, an enhanced role for OHAs. These type of macro social policy solutions may not, however, be able to tackle the sort of organisational-level changes in the nature of work observed by

Baumberg (2014). He notes that a sharp rise in high demand, low control jobs in the UK may disproportionately affect disabled people. This suggests attitudinal and practical (in terms of job design) awareness of problems at an organisational level needs to be addressed also.

The increasing trend in human resource management (HRM) to devolve both budgets and people management to line-managers can create tensions between HR and operational responsibilities, which can become particularly acute when managing ill and disabled employees (Cunningham, James and Dibben, 2004). Since many of the tensions between competing organisational priorities are increasingly played out at this level, Cunningham et al. (2004: 274) question whether it is possible for HRM practice to find a mutually beneficial accommodation of employee and organisational needs – bridging the gap between the 'rhetoric of mutuality and its reality'. Line-managers are often charged with performing contradictory roles: being asked to be supportive to absent, ill or disabled employees, whilst also being tasked with taking disciplinary action as part of absence procedures (Cunningham et al., 2004: 276). Tensions can also be created by so-called organisational 'logics' that stereotype disabled employees as unproductive (Barnes and Mercer, 2005), or by normative ableist 'ideal worker' assumptions (Foster and Wass, 2013) that construct disability as negated difference (Williams and Mavin, 2012). Such 'logics' can become increasingly powerful in times of austerity, job losses and work intensification, when the rhetoric of mutuality and employee well-being in HR policies comes under increasing pressure (Cunningham et al, 2004; Taylor, 2013).

There has been limited research in the UK on the actual organisational processes and problems associated with securing appropriate workplace adjustments, despite evidence that suggests their provision can shorten the length of workplace absences and increase the job security of ill or disabled employees (Krause, Dasinger and Neuhauser, 1995; Franche, Cullin, Irvin, Sinclair and Frank, 2005). Meager, Bates, Dench, Honey and Williams' (1998)

UK survey of disabled workers found that more than a quarter of respondents felt they could have remained in their jobs, had appropriate workplace adjustments been made. Common adjustments include alterations to working hours, job roles, or the provision of equipment – all dependent upon line-managers' understandings of existing job roles (Foster, 2007). However, recurrent reports allege continued widespread ignorance of UK disability law amongst employers, managers and even union representatives (e.g. Stacey and Short, 2000; Foster, 2007; Trades Union Congress (TUC), 2013: 4). Significantly, the goodwill of individual line-managers was found to be the most important factor in determining whether employees secured appropriate adjustments or not (Cunningham et al., 2004; Foster, 2007), providing opportunities for abuse (Fevre et al., 2013), a finding mirrored in Australian research on female employees with chronic conditions (Werth, forthcoming). Research by Foster (2007), Taylor et al. (2010), Foster and Fosh (2010), Foster and Wass (2013) and Fevre et al. (2008; 2013) into employee workplace experiences makes depressing reading. Multiple examples of requests for adjustments are highlighted resulting in unfair dismissal; conflicts between line managers and occupational health physicians about the capability of an employee; instances of bullying and stress caused by ill-treatment in the process of negotiating adjustments; poor union representation and lack of guidance from anyone in HR. This suggests a significant gap between policy and practice in organisations, which extends to the public sector, where despite the presence of a more developed professional HR role and higher levels of unionisation, a culture of 'buck-passing' and 'muddling through' persists (Foster, 2007: 73).

The power differentials that exist between managers and individual disabled employees and the sometimes ambiguous role of managers in supporting and disciplining points to a need for a wider HR framework of disability management in the workplace. Amongst other things, this is essential to regulate fairly the provision of adjustments

throughout organisations, which in essence can constitute changes to terms and conditions of employment (Foster and Fosh, 2010); to facilitate the involvement of other actors, for example OHAs and union representatives; and to centralise costs of adjustments. Operational pressures have been found to limit the priority line managers give to workplace adjustments (Cunningham et al, 2004: 277) and, if the cost of adjustments is devolved, this will act as a further disincentive. Evidence also suggests (Dibben, James and Cunningham, 2010) that HR involvement in employee return to work plans in the UK is reactive rather than proactive, often only occurring as a consequence of line-management failures. Line managers themselves report feeling ill-equipped to deal with disabled workers and long term employee absences, despite access to resources such as HR and OHA and training (Cunningham et al., 2004: 283), which reinforces Foster's (2007) conclusion that managers prefer to 'abdicate responsibility' in this area. The need for coordinated multi-actor responses at organisational level thus requires further development, if disabled workers' employment position is not to remain precarious.

Methodology

We now explain our secondary analysis undertaken of the 88 qualitative interviews gathered for the WBHB project on ill-treatment experienced. The private and public sector organisations were selected both to give access to sufficient respondents and to provide workplaces with established HR input and worker representation systems (Fevre et al., 2011a: 9) and, by extension, procedures in place for people management and the resolution of problems and disputes. A hitherto unreported fifth case study was also conducted in a smaller charitable organisation with approximately 3000 employees, although employment relations were considerably less mature here. The data was collected in 2008-9 and interviewees were asked about episodes of ill-treatment that may have occurred in the two years prior to

interview. We emphasise two points about this time frame. First, although the reference period included the lead-up to a time of heightened organisational stress because of recession, the purpose of data collection was to uncover the underlying processes of ill-treatment in organisations. Second, this precedes the DDA being superseded by the 2010 Equality Act: since the latter did not change the definition of disability it has no impact on the legal status of any of the interviewees.

Of the 88 interviews, 82 focused upon specific negative workplace behaviours and incidents the respondent had experienced, based upon a pre-interview proforma completed by the respondent. Interviewees were asked contextual information about their jobs, the perceived ill-treatment experienced, the causes and consequences of this ill-treatment, how the individual and organisation attempted to deal with the problems, sources of assistance and support used. Interviewees were also asked what future measures might be taken to prevent ill-treatment arising. In a few of these 82 'individual' cases, participants were also management or trade union representatives able to impart information on wider issues of policy and practice in relation to how negative behaviours in the relevant organisation were dealt with, especially in relation to staff with legally protected characteristics. A remaining six interviews in the NHS and engineering case studies with key managerial or trade union informants focused solely on such broader contextual matters rather than personal ill-treatment.

We analysed the content of all 88 interviews manually, and codified participants' experiences into 27 factors that emerged in more than one interview. 22 of these factors were found in interviews encompassing two or more of the five case studies. This paper extracts for detailed analysis the sub-set of 22 participants, covering four of the five organisations, who disclosed a disability or long-term illness to the original researchers in a pre-interview proforma. As early results from the BWBS had indicated that disability was a more important

correlate of ill-treatment than ethnicity, the original researchers sought particularly to interview disabled employees (Fevre et al., 2011b: 4). Further details on the relationship between the sub-set on which we focus and the full data set are in Table 1. Organisations are referred to by a codename (Logistics, NHS, Charity and Finance, as appropriate), and disabled / ill participants by their interview number within the respective case, in our presentation of findings.

INSERT TABLE 1 ABOUT HERE

Our primary purpose was to plot unusual patterns in the sub-sample's experiences, compared to the full sample. Five of 27 factors arose disproportionately in interviews with the sub-sample: a) performance-oriented managers being unsympathetic to those working while sick or disabled; b) experiences with sickness being treated as a disciplinary matter; c) work not being reallocated when workers go off sick; d) workers' attempts to negotiate reasonable adjustments with the organisation; and e) quality of workplace representation. For the purposes of this paper, themes a)-c) above have been amalgamated into a generic theme 1: *managerial understanding of ill-health and disability*. Factor d) above therefore becomes theme 2). Given our concerns in this paper, factor e) above has been augmented with findings about the roles played by actors such as HR and occupational health services in the disability / ill-health cases. These services' roles formed themes in their own right in the data analysis, although not ones where the disability / ill-health cases figured disproportionately. This broader theme 3) is labelled *organisational interventions into ill-treatment*. Results from the three modified themes were extracted as the basis of this paper.

The use of existing qualitative data to find answers to research questions that differ from the questions asked in the original research is not as common as in quantitative research (Hinds, Vogel and Clarke-Steffen, 1997). However, there has been a growing recognition that qualitative datasets can provide important narratives that discuss issues related to the

primary research questions, but which have never been analysed (Long-Sutehall, Sque and Addington-Hall, 2010: 336). Furthermore, increased access to archived digital data sets, such as those stored in the UK Data Archive, from where this data is sourced, facilitates and encourage this, as a good use of publicly funded research. The aim of a secondary analysis is to address new or adjacent research questions by analysing previously collected data, to 'lend new strength to the body of fundamental social knowledge' (Glaser, 1963: 11). Secondary analysis of data has been used to elaborate on issues that may be distinct from the original analysis (Hinds et al., 1997) or, as in this case, perform additional analysis of a sub-set of the original dataset (Hinds et al., 1997; Heaton 1998). Secondary analysis is also appropriate where access to a particular group may be difficult, as is the case when interviewing disabled employees, or where topics being researched are sensitive (Fielding, 2004; Long-Sutehall et al., 2010) – the case with ill-treatment in the workplace.

As recommended by Heaton (2003, 2004), we outline the purposes of the original study and process of data collection in our first two sections above, referring to key quantitative findings from the WBHB project and the rationale behind conducting further qualitative interviews. We have also been careful to state the purpose of our secondary analysis: to focus on a sub-sample of the qualitative data collected, concerning disabled employees' reported experiences of ill-treatment in the workplace. We acknowledge that, by using data from a study of workplace ill-treatment, interviews will have explored such issues by focusing on negative rather than positive organisational behaviours; we recognise the limitations of such data. However, there is value in interrogating this hitherto unanalysed data to explore HR concerns arising from employee experiences to inform the 'management' of workplace disability issues, as we use it here.

Findings

Participants saw their disability or illness as the direct cause of some or all of the perceived ill-treatment experienced in half of the 22 cases, and ill-treatment exacerbated their conditions in six of these eleven cases. Ill-treatment also worsened the conditions of four of the other eleven cases, even though they did not regard their conditions as causative of ill-treatment. Interviewees frequently ended up signed off sick for lengthy periods with work-related stress as a result of their experiences; often stress aggravated the original impairment. Interviews are analysed according to the three themes identified earlier.

Managerial understanding of ill-health and disability

Organisational receptiveness towards accommodating ill and disabled employees' needs is demonstrable through employers' policies and practices, as mediated by managerial actors. The way in which managers mediate macro pressures to squeeze more out of human assets places sick and disabled workers at the brunt of how managers confront attendance, performance and productivity. Sectoral differences exist in the way these pressures manifest themselves: in Logistics, tighter controls on sickness and absence were the dominant theme, more robust performance management in Finance, while work intensification in the Charity and NHS occurred in the context of financial stringency, structural reorganisation and pressures for reductions in staffing levels.

The intersection between absence management and disciplinary procedures is an obvious flashpoint. Half of the participants with a disability or illness mentioned their employer treating sickness absence as a disciplinary issue. In the financial services firm, disability-related absence was classified differently to other absence and, officially, short-term, unplanned absence should not trigger consequences that could be deemed punitive. However, managers did not always comply, as when a clerical worker with a number of impairments found herself called in for a return to work interview after one day's sickness

absence that was clearly disability-related (Finance 17). The Logistics case study produced frequent complaints (e.g. Logistics 1, 8, 14, 17, 18) of line managers using their discretion to issue disciplinary stage warnings for disability-related sickness, with a view to dismissal by the third stage, even though they were supposed not to. Interviewees believed widely that the organisation used this practice as a means to reduce staff numbers.

Line managers' ability to ease or exacerbate the employee's experience at work was pivotal in influencing perceived ill-treatment. The issues are twofold: the attitudes of managers and how these inform their subsequent actions or inactions. As one illustration, a nurse with various disability and ill-health problems returned from long-term sickness to find that no mail had been opened in her absence. She was cajoled into accepting temporary secondment to another job by unsympathetic new managers, whose attitude to her became more negative when she asked to be moved again: the new job had worsened her arthritis and she disliked working alone. Her line managers then began questioning her capability, claiming this was the reason she had been moved originally, and were more interested in suggesting she retired than addressing her complaints (NHS 19).

Managerial *inaction* also triggered or compounded perceived ill-treatment. In the finance firm (Finance 20), a senior manager's repeated attempts to discuss with three successive line managers how lengthy working hours were exacerbating her health were either ignored or insufficiently addressed through minimal adjustments to resourcing. The interviewee believed this inaction to be caused by line managers' reluctance to allocate more resources. Eventually the employee issued a grievance in an attempt to get the firm to put measures in place to address her worsening health. Similarly, Logistics 5's line manager refused to transfer her to other duties, when she was suffering panic attacks when staffing an office alone, on the grounds that nobody was available to replace her. The interviewee

attributed this to managers' unreceptiveness to such requests from staff perceived to lack sufficient seniority derived through length of service.

Finance provided examples where adjustments would have been appropriate but, instead, managers pressurised staff who failed to meet performance or sales targets. Finance 5, a financial advisor, lost her bonus for not meeting her personal development plan targets: part of the reason she had not was for failing to attend a course to which she was unable to drive because of repetitive strain injury. Similarly, a disabled financial advisor was required to reattend a training course, even though he was taken ill when he originally attended, and lost earnings as a result (Finance 19).

The consequences for the participants of managers prioritising performance expectations sometimes crossed the line into what was perceived as bullying or harassment. Examples include overzealous attempts to get a delivery sorter to return from sickness absence (Logistics 6), even to the extent of a manager texting all members of a team to inform them that requests for leave could not be honoured due to the sickness of one member (NHS 13, who also received this text while off sick), reducing the proportion of work covered by other employees while a worker was trying to ease their way back into the job (Logistics 16), and requiring a learning support assistant to do manual work that aggravated a known back injury (Charity 8).

The pressure of tight staffing levels was borne particularly by disabled employees. The halving of support staff levels triggered Charity 8 and NHS 13's problems. To cope with the pressures, disabled employees sometimes resorted to devising their own solutions. For instance, Logistics 6, a delivery sorter, moved down from full- to part-time employment to overcome the lack of sympathy she experienced from fellow employees asked to pick up heavy duties on her behalf.

Difficulties negotiating reasonable adjustments

Line managers were key interlocutors in the negotiation of adjustments requested by disabled interviewees. In an environment where neither interviewees nor their line managers appeared knowledgeable about this aspect of disability law, but power is skewed towards the latter, numerous problems flowed. A disabled delivery sorter (Logistics 8) had been faced with managers' denials that suitable alternative jobs existed to which she could be moved. Logistics 17's testimony undermines such assertions, however: she noted that established managers with knowledge of disabled employees are sympathetic to requests to move to different tasks, but new managers have to be persuaded. Such idiosyncracies are confirmed by the contrasting cases of two disabled workers: office worker Logistics 1 was transferred from deliveries to lighter duties, whereas delivery worker with osteoarthritis Logistics 3 was refused transfer to light work by her manager on the grounds that 'you can either do the job or you can't'. Similarly, NHS 13, a support worker suffering side effects from medication taken for depression and chronic neck pain was also refused temporary redeployment by her managers to lighter duties, despite having Occupational Health (OH) advice to this effect.

Unsurprisingly, the inequity of reliance for adjustments on the knowledge and goodwill of individual managers stoked perceptions of ill-treatment. A disabled expenses officer, Finance 17, found that line managers tended to forget the need to make adjustments unless reminded. Such problems are clearly exacerbated where managers change frequently, as in the case of delivery worker Logistics 9, whose adjustments agreed in writing with one manager were summarily rescinded by another.

Organisational interventions into ill-treatment

This section reports on the interviewees' experience of HR and OHA interventions. We also consider the perceived effectiveness of how interviewees were supported, where applicable, by employee representatives. Table 2 summarises these interventions for the sub-set of cases detailed in this paper.

INSERT TABLE 2 ABOUT HERE

The role of the organisations' HR departments in the cases concerned was less preventative than reactive, emollient, sporadic and haphazard. In some respects, involvement can be considered important as a form of 'organisational memory' to forestall problems. Reprising earlier findings about discontinuities between different or successive line managers, Finance 17 claimed that HR were generally unwilling to suggest possible adjustments and tended not to inform new managers of an employee's disability, leaving the onus on the individual to notify the manager and ensure the continuity of adjustments.

HR interventions were most frequent once disputes had reached a fairly advanced stage and, especially, once formal procedures had been invoked (particularly relevant to the NHS case). Such belated entry creates difficulties, however, as disputes endangered organisational and managerial reputations by this juncture. Where HR did intervene, the few interviewees who expressed an opinion experienced HR's role negatively. In some cases, interviewees found HR to be lacking information about their cases, and even complicit in ignoring the organisation's own policies, although obviously we cannot verify this (e.g. NHS 19, Charity 8).

OHAs were involved in just over half the disability and sickness cases. There was considerable variability between interviewees, even in the same employer, as to their knowledge of the organisational circumstances under which reference to OH might occur. Where interviewees expressed a view, the perceived quality of OH interventions tended towards the negative. Problems included OHAs lacking necessary information (Logistics 16) and OHAs failing to send their decision to the interviewee (Logistics 9).

The increased physical remoteness of HR and OH emerges from the data set as part of the explanation for perceptions of disquiet about their interventions. It is true that the distancing of HR and OH functions was mentioned most emphatically in the engineering case

study, in which no interviewees disclosed a disability or illness, but the *leitmotif* also emerged in the other case studies. Accessibility and quality are linked issues here, especially for disabled employees. Some interviewees in Logistics referred unfavourably to both the quality of OH services accessible either off-site or by phone compared to their former, local presence, and of central welfare services accessible only by phone. Similarly, Finance 17 noted that the withdrawal of a nurse on-site made it more difficult to access medical assistance. Overall, employees' access to sources of informal HR and /or OH advice on-site or nearby seemed very patchy. It seems reasonable to suggest that the inability to access such 'low cost' expertise has adverse implications for the containment of problems and for employee well-being in an era where the use of shared services, outsourcing and electronic access to such services is increasing.

All case study organisations except the charity were unionised, while the third sector organisation had management-appointed works council representatives. Employee representatives were involved in advocacy for employees in eight of the twenty two cases, usually by the time the disputes had reached an advanced stage. In some cases, notably in the heavily unionised Logistics, interviewees did not seek union support: they either rated the local representatives poorly or believed the union would not consider their circumstances sufficiently major. Where members sought representation, the data suggests that the support provided was of variable quality. Five cases were positive about the way they were represented and three a negative opinion. Logistics 14 sought the assistance of the upper levels of the union as she believed the union locally to be ineffective. In particular, a number of represented and unrepresented interviewees in Logistics (e.g. Logistics 8) suggested that the branch level of the union was unwilling to support workers needing to move to lighter work, as this would upset the established tacit seniority system according to which particular jobs were allocated. This suggests an unwillingness to relinquish traditional conceptions and

practices of overall job allocation in the face of the particular needs of disabled employees. Other negative views towards the quality of representation concerned a perceived lack of support or ability on representatives' part, notably in the charity's works council, where Charity 8 was ultimately dismissed in a procedure replete with problems that a more experienced and independent representative might have been able to exploit.

Discussion

Ten years after Cunningham et al. (2004) were reporting organisations' difficulties managing the needs of disabled and ill employees, our analysis, combined with large-scale quantitative results from the WBHB, confirm that disturbing ill-treatment continues to be experienced by this group in the UK workplace, even in large organisations. Our own analysis focused on the perceived negative behaviours of employers, and particularly line managers, which can often be pivotal at an organisational level to disabled workers remaining in employment. We thus return to the question posed in our introduction: how might ill-treatment reported by disabled workers be resolved by workplace actors, particularly HR practitioners? Importantly, we argue that some of the answers can be found in the individualised, fragmented, uncoordinated, deinstitutionalised and employer-dominated approach towards managing disability and long-term ill-health in the UK.

Turning to our first theme, employers' policies and practices remain a key concern, particularly the use of sickness absence, capability and disciplinary procedures against employees who are absent for disability-related reasons. Data was collected before the passage of the 2010 Equality Act, which replaced the DDA, but introduced legal provisions for the first time that protected disabled employees in employment from indirect discrimination. The UK TUC (2013) has actively encouraged union representatives to bargain with employers separate sickness absence procedures for disabled staff, to avoid

triggering disciplinary procedures that might be considered as indirectly discriminatory. However, case law (Griffiths v Department of Work and Pensions [UKEAT/2014/0372_13_1505]) – currently referred to the Court of Appeal at the time of writing – condones employer policies that subsume disability-related sickness into mainstream absence management and disciplinary procedures. Furthermore, any such protections would only apply to disabled employees confident about disclosing their disability (according to the BWBS, particularly relevant to mental health impairments) and would not cover employees absent because of stress (not a recognised disability under UK law) through overwork, work intensification, ill-treatment or bullying. Protections also depend on employees' knowledge of the law and ability and willingness to enforce it. Our data reveals both to be problematic, even after two decades of disability law.

In relation to our second theme – difficulties negotiating workplace adjustments – the important role that line managers play in this process is borne out by the data examined here and reinforces findings in existing literature. The devolution of HR 'down the line', described by Cunningham et al. (2004), appears to us central to the persistence of this problem. Positive organisational policies may exist, but some actors – in this case line managers – are given an increasingly autonomous role in interpreting and enacting policies and can claim managerial prerogative over other organisational actors (e.g. HR and OHAs). The problem is compounded if line managers have to make calculations between the competing performance and budgetary demands that assail them. Qualitative data reveals the role of line managers to be the key variable in determining whether the treatment of ill and disabled employees flares into disputes, and the likelihood of those disputes escalating into protracted procedural quagmires or periods of sickness absence. Repeatedly, the data indicates employees raising their concerns with managers, but little 'people management' being undertaken until an advanced stage and at considerable cost. Existing literature (e.g.

Cunningham et al., 2004; Taylor, 2013), and this data, suggests the pressures facing line managers may vary in different sectors. However, line manager behaviour is primarily shaped by economic concerns being prioritised over people management, all the more so where potentially complex medical concerns enter the equation. Too often, managers' initial responses were either inconsistent or ill-considered, perceived as unsympathetic to employees' entreaties (Dibben et al., 2010; Fevre et al., 2013), and often show a reluctance to seek specialist HR or medical advice until late in the day. For all the above reasons, the data reassert Foster's (2007) picture of the continuing dependence of sick and disabled employees needing adjustments on the 'goodwill' of their line managers, in the absence of any discernible organisational policy on the determination, recording and review of such needs in even large organisations. Chance thus continues to play an unacceptable role in determine whether employees secure adjustments.

The outcomes of interactions with line managers thus influence profoundly to what extent agencies internal or external to the organisation are then involved. Fevre et al. (2011a: 34) suggest that unconfident, overworked line managers, who do not see staffing as their primary concern, too readily divert personnel problems into structured formal procedures overseen by other organisational actors that distance the possibility of rapid resolution. The qualitative data suggests that they are equally likely to attempt improvised solutions first, which exacerbate the resolution of problems if the dissatisfied employee either goes off sick or appeals beyond the line manager. Better handling of such issues at line level, and an appreciation of the utility of such managers having the competence to resolve staffing problems in harmony with organisational policies, might have forestalled the escalating ill-treatment perceived by interviewees.

Where does this leave the organisational coordination of responses to the management and treatment of staff with disabilities and long-term illness (theme 3)? Previous research

finds coordinated responses lacking (Cunningham et al., 2004). Foster and Wass's (2013: 12) analysis of disability discrimination cases found a frequent theme to be managers overruling the advice of OHAs and in some cases HR. This data amplifies such concerns. The often ambiguous role of OHAs, who are charged with making medical recommendations that can be viewed with suspicion by both managers and employees alike, require mediation by other organisational actors such as HR or union representatives. While HR sometimes intervened against line managers, its predominant approach was reactive, and sometimes perceived as being compromised by role conflict.

Conclusions and wider policy implications

When the DDA was first introduced in the UK it was accompanied by the setting up of the Disability Rights Commission (DRC). A potentially educative process was established, with the DRC providing advice to employers and employees, although its statutory role in relation to prosecuting acts of disability discrimination was limited. The DRC has since been merged into the Equality and Human Rights Commission (EHRC). Disabled employees have lost expertise and individual legal case work representation during this merger and the EHRC has encountered cuts in funding. The system of individual litigation that dominates in the UK, alongside the limited role of the EHRC and the increasing reluctance of cash-strapped trade unions to litigate, has meant that poor practice in the workplace is often left unexposed. It is at the level of the workplace that more research needs to be done to highlight everyday unacceptable practices and ill-treatment. The UK workplace is one where managerial prerogative around the logic of operational autonomy has increased and people management has become a devolved and marginalised part of this equation. Central HR and OHAs appear to be increasingly sidelined: their recommendations and organisational policies are not always followed and are, in any case, often regarded as 'advisory'. Furthermore, some of the

data reported here suggests that the tendentious status of HR and OH as a resource in dispute resolution is exacerbated by their decreasing accessibility to workers, because of their transition from physical to 'virtual' presences. This atrophies sources of immediate help and advice for all parties and makes the likelihood of a coordinated approach to workplace disability issues more remote.

At a policy level, the UK Government's new Fit for Work (FfW) service, launched in 2014 in response to Black and Frost's (2011) official review of sickness absence, is relevant, but perpetuates the voluntaristic approach to OH advice. General practitioners can refer employees on sick leave for four weeks to an OH specialist, who will be able to make recommendations to the employer about what is needed for a return to work. This is potentially powerful, but line managers and employers may be no more willing to accept such advice than in the past.

This research has certain limitations. Interviewees were volunteers within large organisations willing to recount experiences of ill-treatment. The research identifies examples of particularly bad organisational practices that constitute atypical 'critical cases', and reported typical or good practice in the treatment of employees is inevitably rarer. In giving voice to the employee, the data is by definition untriangulated. The study's purpose is to uncover *perceptions* of ill-treatment and its effects, and other organisational actors may well not concur with the descriptions of events. As a purposive study, the data set comprises a relatively small sample size of workplace cases, and our analysis is of a subset of one quarter of these to identify the specific experience of interviewees reporting disability or long-term illnesses.

The data contain some clear implications for HR practice and public policy. The interviews indicate strongly that managers need to enhance the priority they give to prevention and early resolution of employees' difficulties in relation to disability and long-

term sickness before disputes can escalate. However, this must be accompanied by support and resources internal – and probably external – to the organisation to enable them to prioritize staffing problems to the same extent as their other line responsibilities. HR and OHAs' presence need to be proximate and tangible in intervening with managers and workers facing ill-health and potentially requiring adjustments. The lack of central organisational repositories for information on staffs' adjustments and the facility to manage proactively such need is untenable. Indeed, there may be merit in having a specialist unit within organisations to oversee disability issues. Overall, there remains a pressing need within UK organisations and public policy for the effective reinstitutionalisation of responsibility for the management of disabled and sick employees.

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Table 1. Data sources, by organisation

Case study organisation (and codename)	No. of interviews	Of which, with stated disability or long-term illness
1. Logistics and communication (Logistics)	19	11
2. Financial services company (Finance)	20	5
3. National Health Service trust (NHS)	22	4
4. Third sector organisation providing learning opportunities for disabled people (Charity)	9	2
5. Engineering company	20	0

Table 2. Sources of intervention or support: interviewees with sickness or disability

Organisation	Case	HR involved?	Perception of HR involvement	OH involved?	Perception of OH involvement	Employee representative involved	Perception of representative's support	Notes
Logistics	1	No		Yes	Not stated	No		
	3	No		Medical involvement, but unclear whether was OH	Remote	No		
	5	No		No		No		
	6	No		Yes	Not stated	Yes	Positive	
	8	No		Yes	Less good than in former times	No		Negative view towards involving union
	9	No		Yes, and other medical involvement	Not stated	No		
	14	No		Yes		Yes	Negative locally	
	16	No		Yes	Negative	Yes	Positive	
	17	No		Yes	Positive	No		
	18	No		Yes	Not stated	Yes	Positive	
	19	No		No		Yes	Positive	
Finance	5	No		No		No		
	17	Unclear		No		No		
	18	No		No		No		
	19	Yes	Not stated	No		No		
	20	Yes		Yes	Not stated	No		Employee Assistance Programme used
NHS	2	Yes		Yes		No		
	6	No		No		No		
	13	No		Yes	Negative	Yes	Negative	Also used own general practitioner
	19	Yes	Negative	Yes	Negative	Yes	Positive	
Charity	3	No		No		No		
	8	Yes	Negative	No		Yes	Negative	